EN-002-02

CONNECT for HEALTH COLORADO

Individual Connect for Health Colorado Addendum

Instructions: If you are submitting this application through Connect for Health Colorado, please fill out and submit this addendum as well. If you have more people to include, make a copy of these pages and attach.

Privacy Statement

Connect for Health Colorado (the Marketplace) and the Department of Health Care Policy and Financing will leave your information private as required by law. However, if you chose to apply for financial assistance, the Department of Health Care Policy and Financing can use or share the information if you or your family members apply for or already receive medical assistance with other program(s). The information can only be used for purposes of treatment, payment, determining eligibility, and other program and administrative operations or other purposes permitted by law. Your answers on this form will only be used to determine eligibility for health insurance or help paying for health insurance. Demographic information on race and ethnicity will not be provided to the insurance carriers. If you are an American Indian or Alaska Native, the information will be shared with carriers as this could positively affect your benefits. We will check your answers using information in our electronic databases and the databases of partner agencies. If the information does not match, we may ask you to send us proof.

Health insurance carriers can no longer deny coverage based on your health status. If you are seeking financial assistance, we may ask you screening questions about your medical history to help us determine which assistance programs you are eligible for – this information is not used to determine your insurance rates. Household members who do not want insurance will not be asked questions about citizenship or immigration status.

Important: Connect for Health Colorado and the Department of Health Care Policy and Financing are authorized to collect information on the application, including Social Security numbers, and will confirm information that may affect initial or ongoing eligibility for all persons listed on your application. You are allowing Connect for Health Colorado and the Department of Health Care Policy and Financing to use Social Security numbers and other information from your application to request and receive information or records to confirm the information in your application. You release Connect for Health Colorado and the Department of Health Care Policy and Financing from all liability for sharing this information with other agencies for this purpose. For example, Connect for Health Colorado and the Department of Health Care Policy and Financing may get and share your information with any of the following agencies: Social Security Administration; Internal Revenue Service; United States Customs and Immigration Services; Department of Homeland Security; Centers for Medicare and Medicaid Services; Colorado Department of Labor and Employment; Financial institutions (banks, savings and loans, credit unions, insurance companies, etc.); child support enforcement agencies; employers; courts; and other federal or state agencies. We need this information to check your eligibility for health insurance or help paying for health insurance and to give you the best service possible if you choose to apply.

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☐ **By checking this box,** I agree to allow my information to be used and collected from data sources for this application. I have consent for all people I list on the application allowing collection of information about them from data sources for this application.

Individual Shared Responsibility Exemption

1. Do you have an individual shared responsibility exemption*? ☐ **Yes** ☐ **No**
   If yes, Exemption Certificate Number: _____

American Indian/Alaska Native

2. Are you or is anyone in your family a member of a Federally-recognized Tribe?
   ☐ **Yes** ☐ **No** If **Yes**, complete the information below for each family member (as applicable):

First name, Middle name, Last name, & Suffix	Tribe name and State
First name, Middle name, Last name, & Suffix	Tribe name and State
First name, Middle name, Last name, & Suffix	Tribe name and State
First name, Middle name, Last name, & Suffix	Tribe name and State

No Social Security Number

3. Which applicants do not have a Social Security Number?

First name, Middle name, Last name, & Suffix

Why?

☐ Has applied for SSN ☐ Illness ☐ Religion ☐ Newborn ☐ Legally Present Non-Citizen

First name, Middle name, Last name, & Suffix

Why?

☐ Has applied for SSN ☐ Illness ☐ Religion ☐ Newborn ☐ Legally Present Non-Citizen

First name, Middle name, Last name, & Suffix

Why?

☐ Has applied for SSN ☐ Illness ☐ Religion ☐ Newborn ☐ Legally Present Non-Citizen

First name, Middle name, Last name, & Suffix

Why?

☐ Has applied for SSN ☐ Illness ☐ Religion ☐ Newborn ☐ Legally Present Non-Citizen

Spouse at Different Address

4. Does the spouse named within the primary application live with you at the same physical address?

☐ **Yes** ☐ **No** **If no**, complete the information below:

5. Legal name of spouse (First name, Middle name, Last name, & Suffix)

6. Address	7. Apartment or suite number	
8. City	9. State	10. ZIP code

Assistance with Completing this Application and Addendum

You can choose an authorized representative.

This trusted person would be given permission to talk about this application and addendum with Connect for Health Colorado, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative" and takes legal responsibility for the information provided in this application. If you ever need to change your authorized representative, contact Connect for Health Colorado.

11. Name of authorized representative (First name, Middle name, Last name, & Suffix)

12. Address	13. Apartment or suite number	
14. City	15. State	16. ZIP code

17. Phone number ( ) – Ext. _____	Phone Type: ☐ Cell ☐ Home ☐ Work

18. Email Address

19. Company/Organization name (if applicable)

20. Company/Organization ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.

21. Your signature	22. Date (mm/dd/yyyy)

Individual Connect for Health Colorado Addendum - Continued

For certified application counselors, health coverage guides, agents, and brokers only.

Complete this section if you are a certified application counselor, health coverage guide, agent, or broker filling out this application

23. Application Start date (mm/dd/yyyy)

24. Select one:
☐ counselor ☐ health coverage guide ☐ agent/broker

25. First name, Middle name, Last name, & suffix

26. ID Number (Guide ID or state license number, as applicable)

☐ I, the **authorized representative**, would like to submit proof of a legal reason that PERSON 1 cannot represent themselves. (Please provide a copy of one of the following documents with this application when it is submitted: a power of attorney, court order establishing legal guardianship, or other legal document explicitly stating that you may legally act on behalf of the customer.)

Terms and Conditions

1. I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible copy signature shall have the same force and effectiveness as the original.

2. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued. I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

3. I know I have **30 calendar days** to report any changes to the information I listed on this application to Connect for Health Colorado if I am enrolled in a Qualified Health Plan.

4. Following federal law, discrimination is not permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file

5. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

6. I have agreed to submit this application for myself and/or my family. By signing this application, I certify that I have reviewed this application; that I understand and agree to the statements in the Terms and Conditions section; and that under penalty of perjury, I certify the information I have given is true. This means I have provided true answers to all the questions on this form to the best of my knowledge. I know that if I am not truthful, there may be a penalty. Penalties may include imprisonment, fines, denial of insurance, and civil damages.

Individual Connect for Health Colorado Addendum - Continued

Terms and Conditions - continued

My right to appeal:
If I think Connect for Health Colorado has made a mistake, I can appeal its decision. To appeal means to tell someone at Connect for Health Colorado that I think the action is wrong and ask for a fair review of the action. I know that I can find out how to appeal by contacting the Marketplace at 1-855-PLANS-4-YOU or by visiting our website at ConnectforHealthCO.com. My eligibility and other important information will be explained to me.

Sign this addendum. The primary policy holder should sign this addendum. If you are an authorized representative, you may sign here as long as you have provided the required information in the Assistance with Completing this Application and Addendum section.

Signature	Date (mm/dd/yyyy)

Mail completed application and addendum

Connect for Health Colorado
Individual Applications
P.O. Box 35033
Colorado Springs, CO 80935

ConnectforHealthCO.com
1-855-PLANS-4-YOU (1-855-752-6749)
Note: If you need help in a language other than English, call and tell the customer service representative the language you need.
En Español: Llame a nuestro centro de servicio gratis para ayuda o para obtener una copia de este formulario en Español, al 1-855-PLANS-4-YOU (1-855-752-6749)
TTY/TDD: 1-855-346-3432

* Individual shared responsibility exemption: You may be exempt from the federal requirement to have health insurance if any of the following apply: you are a legal resident of the United States with very low income but you do not qualify for Medicaid, you are part of a religion opposed to acceptance of benefits from a health insurance policy; you are a member of an American Indian or Alaska Native Tribe who is eligible to receive services through an Indian health care provider (such as the Indian Health Service (IHS), a Tribal health program, or urban Indian health programs); or you qualify for a hardship exemption due to very low income. If you qualify for an exemption, you can either opt-out of having health insurance (and do notneed to fill out this application) or purchase a high-deductible plan through the Marketplace once you have the exemption. To find out how to apply for the exemption, contact one of the following: the Federal government at healthcare.gov, 1-800-318-2596, or TTY at 1-855-889-4325 OR you may contact Connect for Health Colorado by starting an online chat at ConnectforHealthCO.com using the 'Get Assistance' button or by calling 1-855-PLANS-4-YOU (1-855-752-6749).